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No. 88-1503

IN THE

Supreme Court of the United States

October Term, 1989

NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN,

Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, and ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,

Respondents,

v.

THAD C. McCANSE, Guardian ad litem,

Respondent.

On Writ of Certiorari to the Missouri Supreme Court

BRIEF OF THE AMERICAN GERIATRICS SOCIETY AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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BRIEF OF THE AMERICAN GERIATRICS SOCIETY AS *AMICUS CURIAE* IN SUPPORT OF THE PETITIONERS

STATEMENT OF INTEREST OF *AMICUS CURIAE*

The American Geriatrics Society (AGS) is an organization of physicians and related professional health care providers whose special concern is with the health care needs of elderly persons. The AGS

was founded in 1942 and currently maintains a roster of approximately 5,300 dues-paying members. The AGS sponsors conferences and seminars, provides for collegial information-sharing, publishes a pre-eminent professional journal (*The Journal of the American Geriatrics Society*), and encourages improved health care services for elderly persons and research on the illnesses from which they suffer.

The AGS and its members have had a long tradition of concern about the establishment of standards regarding care of ill or dependent elderly persons. The AGS has tried to assure that even those elderly persons with severe dependency and limited personal and community resources gain access to the best possible health and supportive services. To that end, AGS has placed a high priority upon encouraging health care providers, the elderly, and their families to adopt an optimistic and energetic approach to treatment of illness.

Although Nancy Cruzan is only 32 years old, the ultimate disposition of the issue in this case will have serious implications for the care of the elderly. How the Court addresses this issue will determine substantially the choices available to the elderly to plan the ways they will live, and particularly the ways they will die. The AGS urges that all parties involved not lose sight of the tragedy and poignancy of the experience of suffering patients and families.

In its Position Statement, *Medical Treatment Decisions Concerning Elderly Persons*,[1] the AGS affirms:

> (a) A strong commitment to personal autonomy of patients;
>
> (b) Both an appreciation of the beneficial potential of modern medicine and honesty regarding its side effects and limitations;
>
> (c) An affirmation of the inestimable value of life; and
>
> (d) A clear recognition of the inevitability of death.

[1]App. at 1a.

Central to the AGS's commitment to these principles is the protection of the standard for good medical decision-making. This standard takes into account the well-being of the patient as understood according to the patient's own values and life goals, to the extent that they can be known. A critical obligation of health care professionals is to ascertain the potential treatment options for a patient and, together with the patient or the patient's representative, determine which course of action best promotes the patient's interests.[2]

In its Position Statement, the AGS states as follows:

> Patients' interests are not always best served by applying all theoretically beneficial treatments. Instead, the choice made should reflect that patients often have legitimate concerns about avoiding suffering, advancing their occupational or family concerns, mitigating disability, and sustaining independence. Particular medical interventions may not be warranted in light of overall effects on well being, although they may be expected to help a particular medical condition.
>
> When patients cannot be informed or cannot reason about the available options in light of their own preferences and goals, the physician should, for any important decision or ambiguous choice, involve someone who knows the patient and can represent the patient's wishes in making the choice.

[2]U.S. Congress, Office of Technology Assessment, *Life Sustaining Technologies and the Elderly*, OTA-BA-306 141-166 (1987) [hereinafter OTA]; The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying 18-34* (1987) [hereinafter Hastings Center *Guidelines*]; President's Commission for the Study of Ethical Issues in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions* 15-39 (1982) [hereinafter President's Commission, *Making Health Care Decisions*]; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* 43-90 (1983) [hereinafter President's Commission, *Deciding to Forego*].

> Caregiving professionals and institutions should make available to patients a full range of options for treatment, including the option of supportive care for dying patients.[3]

Most of the patients served by members of the AGS are individuals who have long life histories. Over many decades they have developed an ordered set of preferences, made choices based on religious and other value commitments, and have been substantially in control of their own lives. AGS members have been in the forefront of efforts to recognize and respect this fact and have worked to ameliorate the common age-based abrogation of a person's authority to continue to direct the course of his or her life.[4] AGS is committed to protecting the authority of the patient to make choices concerning future medical care, including the forgoing of artificial nutrition and hydration, regardless of whether decision-making capacity may become impaired.

The question of forgoing nutritional support is of particular concern to elderly patients. There are common conditions among the elderly, such as stroke and dementia, in which patients can be maintained through the medical provision of nutrition and hydration for long periods. Elderly patients are also especialiy likely to suffer from the side effects of providing nutritional support including rehospitalizations, restraints, infections, and bedsores. Some might reasonably choose to avoid these burdens and accept an earlier death. Incapacity to make decisions is also a common problem for the elderly. Nearly a quarter of all adults surviving to age 80 will suffer a progressive dementing disorder prior to death,[5] and the vast majority of Americans will have a time in their lives when they do not have the capacity to make health care decisions, because of acute illness, dementia, or disorientation near death. To interfere with

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[3]App. at 1a-2a.

[4]ABA, *Advanced Age of the Alleged Incompetent*, Report 106 A, B, § II.C, in *Summary of Actions of the House of Delegates: 1987 Annual Meeting* 14-18 (Aug. 1987).

[5]Cohen & Eisdorfer, *Dementing Disorders*, in *The Practice of Geriatrics* 194 (1986).

a patient-centered standard for decision-making would be to deny millions of elderly patients and other adults an individualized decision regarding their health care and could require physicians to practice medicine in violation of their professional standards.

For the foregoing reasons, the AGS wishes to offer to this Court its view on the issues in this case. Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. Letters of consent have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

In the decision below, a severely divided Supreme Court of Missouri precluded the cessation of life-sustaining medical treatment -- artificial hydration and nutrition -- to Nancy Cruzan because of the state's purported unqualified interest in life and the fact that the treatment was not burdensome to Ms. Cruzan. The majority eviscerates the patient's constitutionally protected right to forgo medical treatment and significantly limits the ability of a mentally disabled patient to exercise this right. The majority also jeopardizes the ethical integrity of the medical profession by allowing the state to interfere in the medical decision-making process.

The well established standard for good medical decision-making is patient-centered, promoting the individual's well-being according to his or her own values and preferences, and involves the participation of the individual, the physician, and frequently the individual's family members. The decision of the court below significantly disrupts the decision-making process by dictating the result of the decision-making process without regard to an individualized assessment of the patient's well-being and in most, if not all, cases causing prolongation of the dying process.

The right to forgo life-sustaining medical treatment is encompassed within the right of privacy or properly characterized as a liberty interest protected by the Due Process Clause of the Fourteenth Amendment. Since the right is not absolute, it must be balanced against competing state interests. The court below failed to accord

due weight to the patient's constitutional rights and predetermined the result of the balancing by finding an unqualified state interest in life and by disregarding the other three recognized state interests. Most importantly, the Missouri Supreme Court overlooked the state's interest in maintaining the ethical integrity of the medical profession. Had that interest been considered, the state would have assumed the proper role of overseeing procedures and arbitrating disputes in the decision-making process currently recognized and practiced by the medical community.

ARGUMENT

I. THE STANDARD FOR GOOD MEDICAL DECISION-MAKING WILL BE COMPROMISED BY THE RULING OF THE MISSOURI SUPREME COURT.

Through the long, thoughtful efforts of doctors, ethicists, and community leaders, a model for good medical decision-making has evolved and become a well-accepted practice among health care providers.[6] For good medical decision-making practices to function effectively and fulfill the purpose of promoting patient well-being, each individual must have the right to forgo[7] life-sustaining medical treatment. This right must be afforded constitutional protection, either under a right of privacy or as a liberty interest under the Due Process Clause of the Fourteenth Amendment. However, the barriers erected by the Missouri Supreme Court to forgoing life-sustaining medical treatment effectively deprive patients of their constitutional protections and cause a significant adverse disruption of the medical decision-making process.

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[6]President's Commission, *Making Health Care Decisions*, *supra* note 2; Hastings Center *Guidelines*, *supra* note 2; American College of Physicians, American College of Physicians Ethics Manual, 111 Annals Internal Med. 327 (1989); Ruark, Raffin & The Stanford University Medical Center Committee on Ethics, *Initiating and Withdrawing Life Support: Principles and Practice in Adult Medicine*, 318 New Eng. J. Med. 25-30 (1988).

[7]The term, "right to forgo," refers to both the withdrawal and withholding of a particular medical treatment.

A. All Choices Among Medical Treatments Should Be Assessed According to the Standard for Good Medical Decision-Making.

The standard for good medical decision-making under any circumstance is that the choice made among treatment alternatives pursues the well-being of the patient, understood according to the patient's own values and life goals to the extent they can be known. The obligation of health care professionals and others interested in the patient's well-being is to ascertain the potential treatment options for a patient and, together with the patient or the patient's representative, decide which actions best promote the patient's interests. These interests may vary widely among different individuals,[8] for each individual has unique goals and values.

Respect for persons and for the integrity of their individual values is an essential feature of good medical decision-making. Society values the uniquely human freedom to structure a meaningful life and to make choices about how best to live that life. When this freedom is limited, it must be done carefully, for there is a risk of devaluing individual lives based on some universalized ranking of values.

When deficits in understanding, communication, or reasoning make a patient unable to be responsible for his or her own decisions,[9] the standard for medical decision-making requires that the decision be made by a surrogate decision-maker collaborating with the physician. An appropriate surrogate decision-maker is one who knows the patient well. The patient's family and, in some situations, the patient's close friends, best fit this requirement. Elderly persons strongly prefer and even assume that families will serve as surrogates, and see this as a way to extend autonomy to future situa-

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[8]*See supra* note 2.

[9]Such a patient may or may not have been determined to be incompetent by a court.

tions of decisional incapacity.[10] Also, to diminish the family's role to mere recorders of past conversations about life-sustaining therapies is to denigrate the values of families and other relationships.

When the person cannot choose for himself or herself, it is important that surrogates be very protective of the patient's life and reluctant to allow it to be foreshortened.[11] However, hesitance and caution should not indicate a sweeping refusal to allow death to occur. There are some conditions that entail such substantial suffering and isolation from loved ones that treatment to prolong such a life should not be required.[12] If it were, the decision-making incapacity itself would become the barrier to the morally correct withdrawal of a treatment which had become unwarranted and harmful.

The Missouri Supreme Court's decision, by excluding certain categories of decisions from the list of alternatives that can be chosen, conflicts with the goal of medicine: to promote the well-being of patients according to their unique values and life goals. One of the factors that the Missouri Supreme Court relies upon in reaching their decision is that Nancy Cruzan is not "terminally ill." 760 S.W.2d at 412, 419. To allow this issue to enter into the analysis is to claim that the standard for good medical decision-making should depend on how close a person is to the time of death. Such a claim has several difficulties.

First, delaying the actual time of death is a value that some may desire to trade-off for other values, such as increased comfort or capacity to interact with others.

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[10]High, *All in the Family: Extended Autonomy and Expectations in Surrogate Decision-Making*, 28 The Gerontologist 46-51 (1988).

[11]President's Commission, *Making Health Care Decisions*, *supra* note 2, at 177-181; President's Commission, *Deciding to Forego*, *supra* note 2, at 132-136. *See also* Buchanan, *The Limits of Proxy Decisionmaking for Incompetents*, 29 UCLA L. Rev. 393 (1981).

[12]President's Commission, *Deciding to Forego*, *supra* note 2 at 3. *See also* Rosner, *Prolonging the Act of Dying*, 31 J. Am. Geriatrics Soc'y 382 (1983).

Second, the empirical data upon which one can base a prognostication of "terminal illness" is necessarily limited. Statutes and public policy statements that use "terminal illness" fail to consider that the prognostication is a statistical one. Statistical data can give only very broad estimates of survival, and are very imprecise when applied to a particular patient.

Third, the definition of "terminal" is itself quite vague. Does it refer to patients who will die soon without therapy, or only to those who will die soon in spite of all therapy? To choose the latter would seriously restrict the control that millions of elderly patients could exercise over lives affected by chronic debilitating and dementing illness.

Finally, a decision to uphold the Missouri Supreme Court's ruling would have the effect of granting each state the authority to alter the standard of patient-centered decision-making and would be devastating to patients and the health care profession. The obligation to respect persons and their authority over their own lives is universal and certainly cannot depend on the individual's state of residence or on the fact that the individual may live in a state-supported institution. Substantial variations would undermine national standards of care[13] and the interstate mobility of health care professionals. An incompetent person under guardianship would present a dilemma if the family wished to move the patient to a state more tolerant of forgoing life-sustaining treatment. Interstate variation would also affect federal regulation of what care is warranted and how quality of care is to be measured under Medicare and other federal programs.

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[13]Legally, the medical profession is measured by national standards. For example, the modern trend in medical malpractice cases has been to replace the locality or community standard of due care with a standard that does not rest on geographic locality. *See, e.g., Gridley v. Johnson*, 476 S.W.2d 475, 482 (Mo. 1972); *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793, 798 (1968); 61 Am. Jur. 2d *Physicians, Surgeons and Other Healers* § 219 (1981).

B. The Missouri Supreme Court Failed To Consider Properly That Artificial Nutrition And Hydration Are Forms Of Medical Treatment.

The Missouri Supreme Court assumes that the medical provision of hydration and nutrition ought to be considered differently from other medical treatments. Although the Court expressly considered the equating of nutritional support with medical treatment as a "semantic dilemma," 760 S.W.2d at 423, the tone of the opinion implies that the majority viewed the distinction as profound. Their analysis begins with the powerful statement, "[t]his is a case in which we are asked to allow the medical profession to make Nancy die by starvation and dehydration," 760 S.W.2d at 412, and further continues with the statement that "common sense tells us that food and water do not treat an illness, they maintain a life." *Id.* at 423.

The "common sense" distinction drawn by the Missouri Supreme Court lacks coherence for two reasons: First, "common sense" might well dictate that a particular treatment for an illness is central to the maintenance of life; yet, no claim is made, or could reasonably be made, that all treatment maintaining life must be imposed upon all potential patients. Second, the cause of death in a situation where medical provision of nutrition and hydration is withheld is not ordinarily understood to be the inoperation of the mechanical means for feeding; rather, death is caused by the underlying condition that prevents the patient from taking nutrition "naturally." When a treatment decision removes a patient from a life-sustaining respirator, the death certificate does not list the removal of the machine as the cause of death, instead it lists the underlying condition that created the inability to breathe on one's own. This "semantic" problem, as the Missouri court labels it, is important because it relates to the way in which causation is perceived and understood in a medical context. There are multiple factors, both behavioral and pathophysiological, contributing to any death, and the naming of a single cause is a normative and social endeavor, not merely a descriptive task.

Additionally, the rationale expressed by the Missouri Supreme Court in claiming that nutrition and hydration is merely needed for survival fails to distinguish nutrition and hydration from other life-sustaining medical treatments. For example, oxygen exchange is needed by all, but artificial respiration can be halted; the removal of soluble toxins is needed by all persons, but dialysis can be halted.[14] Courts addressing this issue have acknowledged no distinction between the decision to forgo artificial hydration and nutrition and the decision to forgo other life-sustaining medical treatments.[15]

Another common misunderstanding causing distortion of a discussion of forgoing nutritional support concerns the patient's actual experience of dehydration and malnutrition versus the chemical imbalance indicated by certain diagnostic test results. There is a universal obligation to attend to a patient's experience of hunger and thirst, but patients who are dehydrated and malnourished according to laboratory tests may not feel hunger or thirst -- most dying or seriously ill patients do not.[16] The value of nutritional therapy must be assessed according to the well-being of the particular patient and sometimes that assessment indicates that efforts should not be made to correct the chemical imbalances. Spoon-feeding can still be of-

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[14]*See, e.g., In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (respirator), *cert. denied*, 429 U.S. 922 (1976); *In re Spring*, 380 Mass. 629, 405 N.E.2d 114 (1980) (dialysis).

[15]*Gray v. Romeo*, 697 F. Supp. 580, 587 (D.R.I. 1988); *In re Conroy*, 98 N.J. 321, 372-374, 486 A.2d 1209, 1235-37 (1985); *Brophy v. New England Sinai Hosp .*, 398 Mass. 417, 438-39, 497 N.E.2d 626, 636-38 (1986); *In re Peter*, 108 N.J. 365, 380-382, 529 A.2d 419, 427-28 (1987); *In re Jobes*, 108 N.J. 394, 413 n. 9, 529 A.2d 434, 444 n. 9 (1987); *In re Gardner*, 534 A.2d 947, 954-55 (Me. 1987); *In re Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840, *cert. denied*, ____U.S.____, 109 S. Ct. 399 (1988); *McConnell v. Beverly Enterprises*, 209 Conn. 692, 705, 553 A.2d 596, 603 (1989).

[16]*See e.g.*, Schmitz & O'Brien, *Observations on Nutrition and Hydration in Dying Cancer Patients*, in *By No Extraordinary Means* 29-38 (Lynn ed. 1989); Cox, *Is Dehydration Painful?*, 9 Ethics and Medics 1-2 (1987); Baines, *Control of Other Symptoms*, in *The Management of Terminal Disease* (1978); Crowther, *Management of Other Common Symptoms of the Terminally Ill*, in *The Dying Patient* (1982).

fered to the patient, both to remain open to the possibility that the patient could eat and to acknowledge the social importance of including the patient in the community of caring throughout dying. Patients in persistent vegetative state (PVS), like Nancy Cruzan, ordinarily can reflexively swallow their own saliva and at least small amounts of food and water.

For the vast majority of patients, medical provision of nutrition and hydration offers substantial benefits that clearly overcome the burdens inherent in the proposed treatment. However, like other forms of medical treatment, the provision of nutritional support itself sometimes cannot succeed even in achieving its physiologic ends and also always carries with it risks and problematic side effects.[17] Nasogastric tube feedings (from the nose to the stomach) commonly cause annoyance and discomfort and frequently require that the patient be placed in restraints. They also may involve a substantial risk of sinus and lung infections or bleeding from the esophagus or stomach, and diarrhea. Gastrostomy feedings (through the abdominal wall to the stomach) require surgical placement of the tube, with associated anesthesia and wound-healing risks, as well as most of the risks of nasogastric feedings. Intravenous fluid therapy (providing soluble nutrients and liquids into a vein in the arm or leg) or parenteral hyperalimination (providing a balanced chemical diet into a large vein in the chest) frequently cause serious ill-effects such as metabolic abnormalities and fluid overload. Any of these procedures commonly entail increased monitoring of blood chemistry and urine output which, themselves, incur risks. There are clear instances where adequate nutritional support causes more harm than

[17]*See, e.g.*, Canizaro, *Methods of Nutritional Support in the Surgical Patient*, in *Surgical Nutrition* 13 (1981); Silberman & Eisenberg, *Parenteral and Enteral Nutrition for the Hospitalized Patient* (1982); Michel, Serrano & Malt, *Nutritional Support of Hospitalized Patients*, 304 New Eng. J. Med. 1147 (1981); Faintauch & Dietel, *Complications of Intravenous Hyperalimentation: Technical and MetabolicAspects*, in *Nutrition in Clinical Surgery* (1980); Rombeau & Caldwell, *Enteral and Tube Feeding*, in *Clinical Nutrition* 1 (2d ed. 1989); Konstantinedes & Shronts, *Tube Feeding, Managing the Basics*, Am. J. Nursing 1312 (Sept. 1983); Stroot, *Fluids and Electrolytes: A Practical Approach* (2d ed. 1977).

good.[18] Dying cancer patients, for example, if given fluids may require uncomfortable suctioning of excess secretions: the condition of patients in heart or kidney failure may actually worsen if fluids are provided.[19]

Many, including the court below, are reluctant to consider the possibility that the risks and harm associated with the medical provision of hydration and nutrition might support a decision to forgo that treatment. The provision of food and water is ordinarily considered to be a basic expression of caring and there is a strong sentiment that all people benefit from its being provided. The evidence, however, is to the contrary.

In much of the literature discussing the issue of forgoing nutritional support, there is concern expressed about the symbolic nature of providing food and water.[20] Society is filled with powerful images surrounding shared meals. Eating and drinking together is an essential part of many cultural and religious rituals. The provision of food and water ordinarily demonstrates loyalty, steadfastness, and commitment to care. However, the medical treatment of severe-

[18]Zerwekh, *The Dehydration Question*, Nursing 47-51 (Jan. 1983); Hushen, *Questioning TPN as the Answer*, 82 Nursing 852-854 (1982); Saunders, Summers & Teller, *Hospice: The Living Idea* (1981); Baines, *Control of Other Symptoms*, in *The Management of Terminal Malignant Disease* (2d ed. 1984); Billings, *Comfort Measures for the Terminally Ill: Is Dehydration Painful?*, 33 J. Am. Geriatrics Soc'y 808-10 (1985); Oliver, *Terminal Dehydration*, ii Lancet 631 (1984).

[19]A recent review of nutritional support in dying cancer patients receiving chemotherapy could find no subgroup of malnourished patients who actually benefitted. American College of Physicians, *Parenteral Nutrition in Patients Receiving Cancer Therapy*, 110 Annals Internal Med. 734-736 (1989).

[20]Derr, *Why Food and Fluids Can Never Be Withdrawn*, Hastings Center Report 28-30 (1986); Callahan, *Feeding the Dying Elderly*, Generations 15-17 (Winter 1985); Capron, *Ironies and Tensions in Feeding the Dying*, Hastings Center Report 32-35 (Oct. 1984); Dresser, *When Patients Resist Feeding: Medical, Ethical and Legal Considerations*, 33 J. Am. Geriatrics Soc'y 790 (1985); Carson, *The Symbolic Significance of Giving to Eat and Drink*, in *By No Extraordinary Means* 84-88 (Lynn ed. 1989).

ly ill persons sometimes challenges these sentiments.[21] The usual community sentiment encouraged by the sharing of meals is difficult to envision when the food is a chemical mixture being dripped through an artifically created opening into the body.[22]

It is, indeed, essential to maintain community attitudes of caring that are represented in actions that advance our shared values. Actions that also symbolize a broader context of caring help to sustain and renew values for future generations. The strong presumption in favor of providing nutritional support can be justified on these grounds. However, such a presumption cannot legitimately be expanded to an imperative always to provide nutritional support since, in some circumstances, nutritional support is harmful. It is hard to imagine how an act that is harmful to its recipient can be regarded at the same time as a symbol of caring.[23]

A distinction drawn by the Supreme Court between nutritional support and other medical treatments would have a profound impact on the care of the elderly who are able to suffer the adverse side effects of artificial nutrition and hydration. Such a result would

[21]Norberg, Norberg, Gittert & Bexell, *Ethical Conflicts in Long-Term Care of the Aged: Nutritional Problems and the Patient-Care Worker Relationship*, 1 British Med. J. 377-378 (1980).

[22]In medical settings, the medical nature of artificial nutrition and hydration becomes apparent. A gastrostomy, for example, is a medically invasive procedure requiring surgical or endoscopic placement of a feeding tube through the abdominal wall into the stomach. The federal government through the Food and Drug Administration (FDA) regulates feeding tubes as medical devices, 21 C.F.R. § 876.5980 (1989), and the "food" provided through the tubes is described in the *Physicians' Desk Reference*, a physicians' guide to pharmaceuticals and diagnostic products. *See, e.g., Physicians' Desk Reference* 1742 (1987). The FDA has issued warnings to medical practitioners of the side effects of such formulas, cautioning that certain formulas are "superb media" for bacteria that might cause gastroenteritis and sepsis. Food Drug Cosm. L. Rep. (CCH) ¶ 41,095 (Nov. 1988). *See also* Brief of Amicus Curiae Concern for Dying at 9-10, *In re Browning*, (Fla.), *pending*, (No. 74-174).

[23]Glover, *A Philosophical Analysis of Substitute Decision-Making: The Case of Ms. Nancy Cruzan*, in 5 Midwest Med. Ethics 10, 13 (1989).

harm not only those who would thereby need to be restrained or operated upon, for example, but also those seriously ill and dying patients at home who would be forced to return to institutions which may be alien, frightening, limiting to freedom, and possibly even hazardous.[24] Thus, a needless barrier will have been erected against the peaceful dying at home that many people would prefer.

II. PURSUANT TO A RIGHT OF PRIVACY OR A LIBERTY INTEREST UNDER THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT, THE CONSTITUTION PROTECTS THE INDIVIDUAL'S RIGHT TO FORGO LIFE-SUSTAINING MEDICAL TREATMENT.

Federal and state courts have recognized that a patient's right to refuse medical treatment is constitutionally protected, whether characterized as within the penumbral right of privacy or as a due process liberty interest in bodily integrity.[25] Since an individual's

[24]*See, e.g.*, Jahnigen, Hannon, Laxson & LaForce, *Iatrogenic Disease in Hospitalized Elderly Veterans*, 30 J. Am. Geriatrics Soc'y 387 (1982); Stell, Gertman, Crescenzi & Panderson, *Iatrogenic Illness on a General Medical Service at a University Hospital*, 304 New Eng. J. Med. 638 (1981); Lo & Dornbrand, *Guiding the Hand That Feeds, Caring for the Demented Elderly*, 311 New Eng. J. Med. 402-404 (1984).

[25]*See, e.g., Bee v. Greaves*, 744 F.2d 1387, 1393-94 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985) (privacy and liberty interests); *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980), *vacated and remanded on other grounds sub nom. Mills v. Rogers*, 457 U.S. 291 (1982), *on remand sub nom. Rogers v. Okin*, 738 F.2d 1 (1st Cir. 1984) (Fourteenth Amendment due process interest and right of privacy, bodily integrity, or personal security); *Gray v. Romeo*, 697 F. Supp. at 585-86 (liberty interest protected by Fourteenth Amendment); *In re Guardianship of Grant*, 109 Wash. 2d 545, 552-53, 747 P.2d 445, 449 (1987) (en banc), *modified*, 757 P.2d 534 (Wash. 1988) (right to privacy); *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674, 682 (1987) (right of privacy); *Brophy*, 398 Mass. at 430-32, 497 N.E.2d at 633-34 (right of privacy, self-determination and individual autonomy, bodily integrity); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 301 (1986) (right of privacy); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1984) (right of privacy, bodily integrity); *Satz v. Perlmutter*, 362

rights to be free from nonconsensual invasions of the body and of personal autonomy and security are fundamental and deeply rooted in this Nation's history, the right of privacy and liberty guarantee of the Fourteenth Amendment properly encompass a patient's right to forgo life-sustaining medical treatment.

The right of privacy is grounded in the penumbras of the First, Third, Fourth, and Fifth Amendments, together with the rule of construction of the Ninth Amendment. *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965). While the Court has cautioned against an expansive interpretation of the right of privacy, *Roe v. Wade*, 410 U.S. 113, 154 (1973), *Bowers v. Hardwick*, 478 U.S. 186, 190 (1986), it has recognized that privacy appropriately protects personal decisions "implicit in the concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937), *overruled on other grounds*, *Duncan v. Louisiana*, 391 U.S. 145 (1968) and *Benton v. Maryland*, 395 U.S. 743 (1969), or those interests that are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977). *See also Bowers*, 478 U.S. at 191; *Paul v. Davis*, 424 U.S. 693, 713 (1976); *Gray v. Romeo*, 697 F. Supp. 580, 584, 585 (D.R.I. 1988).

Under the Fourteenth Amendment, a protected liberty interest must be on "so rooted in the traditions and conscience of our people as to be ranked fundamental." *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (Cardozo, J.), *quoted in Michael H. v. Gerald D.*, ____ U.S. ____, 109 S. Ct. 2333, 2341 (1989). Protected liberty interests include the right "generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men." *Ingraham v. Wright*, 430 U.S. 651, 673 (1977).

That the right of each individual to control medical decisions affecting one's body is deeply rooted in our country's history, tradition, and conscience is reflected in notions of bodily integrity that

So. 2d 160, 161-62 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980) (right of privacy); *In re KKB*, 609 P.2d 747, 751 (Okla. 1980) (right of privacy); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417, 424 (1977) (right of privacy, bodily integrity); *In re Quinlan*, 70 N.J. at 39, 355 A.2d at 663 (right of privacy).

have been recognized since 1891.[26] *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250 (1891); *see Roe v. Wade*, 410 U.S. at 152-53 (Blackmun, J., for the Court), 168 (Stewart, J., concurring); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); *Gray*, 697 F. Supp. at 584-86; *see also Webster v. Reproductive Health Services*, ____ U.S. ____, 109 S. Ct. 3040, 3058 (1989) (plurality opinion); *Griswold*, 381 U.S. at 486 (Goldberg, J., concurring). "In the history of the common law, there is perhaps no right which is older than a person's right to be free from unwarranted personal contact." *Davis v. Hubbard*, 506 F. Supp. 915, 930-31 (N.D. Ohio 1980). It has long been the case that medical treatment by a physician in a non-emergency that is rendered without the patient's informed consent, or exceeds the consent given, has been deemed actionable as a battery or trespass of the person.[27]

As have most states, Missouri has recognized the duty of a physician to inform the patient sufficiently to enable him to make an informed decision regarding the treatment options. *Aiken v. Clary*, 396 S.W.2d 668, 673 (Mo. 1965); *see Douthitt v. United States*, 491 F. Supp. 891, 894 (E.D. Mo. 1980); *see also* Mo. Ann. Stat. § 431.061 (Vernon Supp. 1989) (consent to medical treatment). The principle which supports the doctrine of informed consent is that only the patient has the right to weigh the risks attending the par-

[26] "No right is held more sacred, or is more carefully guarded . . . than the right of every individual to the possession and control of his own person, free from all restraints or interference of others, unless by clear and unquestionable authority of law." *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

[27] *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12, 14-15 (1905), *overruled on other grounds*, *Genzel v. Halvorson*, 248 Minn. 527, 80 N.W.2d 854 (1957); *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562, 564 (1906); *Rolater v. Strain*, 39 Okla. 572, 137 P. 96, 98 (1913); *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92, 93 (1914) (Cardozo, J.), *overruled on other grounds*, *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3 (1957); *Wells v. Van Nort*, 100 Ohio St. 101, 125 N.E. 910, 911 (1919); *Cobbs v. Grant*, 8 Cal. 3d 229, 104 Cal. Rptr. 505, 502 P.2d 1, 7 (1972) (in bank). Missouri recognizes that consent is a defense to assault and battery. Mo. Ann. Stat. § 565.080 (Vernon 1979).

ticular treatment and decide for himself what course of action is best suited for him. *Davis*, 506 F. Supp. at 932. Thus, a common law right to refuse medical treatment emerged from the doctrines of trespass and battery, as they were applied to unconsented touchings by a physician. *Mills v. Rogers*, 457 U.S. 291, 294 n.4, 102 S. Ct. 2442, 2446 n.4 (1982); *Rasmussen*, 741 P.2d at 683; *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738, 743 (1983) (en banc); *Saikewicz*, 373 Mass. at 738-39, 370 N.E.2d at 424. Today, there is a well-established common law right to forgo medical treatment, including life-sustaining treatment. *See, e.g. Rasmussen*, 741 P.2d at 683; *In re Colyer*, 660 P.2d at 743; *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); *Lane v. Candura*, 6 Mass. App. Ct. 377, 383, 376 N.E.2d 1232, 1233 (1978).

In addition, society in general, and Missouri particularly, has traditionally accorded a high degree of protection to the doctor-patient relationship. *See* Mo. Ann. Stat. §§ 191.227 (restricted release of medical records), 491.060 (codification of physician-patient privilege) (Vernon Supp. 1989). Through the relationship that has evolved, a doctor and patient work together to discern medical treatment options and the patient then has the authority to make the ultimate determination of the appropriate course of action, consistent with his or her own values.

Given this long history of a common law right to bodily integrity and personal autonomy, a patient's right to make a personal decision to accept or forgo life-sustaining medical treatment is so embedded in this Nation's history and tradition as properly to be within the right of privacy or to constitute a fundamental liberty interest under the Due Process Clause. In fact, the Missouri Supreme Court reluctantly acknowledged that a right to forgo life-sustaining medical treatment could be protected under the federal constitutional right of privacy. 760 S.W.2d at 418-19.

Extending such constitutional protections is consistent with the Court's earlier decisions. An individual has a privacy interest "in independence in making certain kinds of important decisions."

Whalen v. Roe, 429 U.S. 589, at 599-600 (1977) (footnote omitted). Matters relating to marriage, procreation, contraception, family relationships, and child-rearing and education generally have been within this right of privacy.[28] *Paul*, 424 U.S. at 713. Thus, the intensely personal decision to forgo life-sustaining medical treatment falls squarely within the acknowledged bounds of the right of privacy. Unlike *Bowers*, decisions to forgo such medical treatment have a well-accepted basis in this Nation's history and common law. In the case at bar, new rights are not being discovered, but rather existing protections are being afforded to decisions made necessary by the development of new medical technologies and the resulting artificial prolongation of dying.

III. THE RIGHT OF AN INCOMPETENT PATIENT TO FOREGO LIFE-SUSTAINING MEDICAL TREATMENT MUST BE EXERCISED BY A SURROGATE DECISION-MAKER TO PREVENT EVISCERATING THIS RIGHT.

The Missouri Supreme Court held that Nancy Cruzan's co-guardians did not have the authority to order the withdrawal of hydration and nutrition from Ms. Cruzan. 730 S.W.2d at 426. In deciding that a "guardian's power to exercise third-party choice arises from the state's authority, not the constitutional rights of the ward," 760 S.W.2d at 425, the holding effectively denies an individual a constitutional right solely on the basis of her decision-making capacity. This is a dangerous precedent for it suggests that an individual's constitutional rights increase or decrease in relation to her intellectual

[28] *See, e.g., Carey v. Population Services Int'l*, 431 U.S. 678 (1977) (child rearing and education); *Roe v. Wade*, 410 U.S. 113 (1973) (abortion); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (contraception); *Stanley v. Georgia*, 394 U.S. 557 (1969) (possession of obscene material in own home); *Loving v. Virginia*, 388 U.S. 1 (1967) (marriage); *Prince v. Massachusetts*, 321 U.S. 158 (1944) (family relationships); *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942) (sterilization; procreation). *But see Bowers v. Hardwick*, 478 U.S. 186 (1986) (right of privacy does not encompass right to engage in homosexual sodomy in own home).

capacity and it allows the state to intervene unjustifiably in the decision-making process.

The Supreme Court has recognized that a third party has standing to assert the constitutional rights of others if a substantial relationship exists between the claimant and the third party, assertion of the constitutional right is impossible and the claimant's constitutional right will be diluted or adversely affected if the third party is not allowed to assert it. *See Eisenstadt v. Baird*, 405 U.S. at 445-46; *Griswold v. Connecticut*, 381 U.S. at 481 (1965). Consistent with this position, the Supreme Court has acknowledged that "[t]he law must often adjust the manner in which it affords rights to those whose status renders them unable to exercise choice freely and rationally. . . .[T]hose who are irreversibly ill with loss of brain function. . .retain 'rights'. . .but often such rights are only meaningful as they are exercised by agents acting with the best interest of their principals in mind." *Thompson v. Oklahoma*, ____ U.S. ____, 108 S. Ct. 2687, 2693 n. 23 (1988) (plurality opinion).

Numerous jurisdictions have recognized that the right to forgo life-sustaining medical treatment survives incompetency of an individual and also explictly or implicitly recognize the necessity of a surrogate decision-maker to exercise the individual's right.[29] As recognized by state courts, legislatures, and the ethical standards of the medical community, the appropriate surrogate decision-maker,

[29]*See, e.g., Rasmussen*, 154 Ariz. at 219, 221, 741 P.2d at 686, 688; *In re Conroy*, 98 N.J. at 359, 486 A.2d at 1229; *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. at 127, 482 A.2d 713, 718 (Super. Ct. 1984); *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921, 923 (Fla. 1984); *In re Barry*, 445 So. 2d 365, 370 (Fla. Dist. Ct. App. 1984); *In re Colyer*, 99 Wash. 2d at 123, 660 P.2d at 744, *modified on other grounds, In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1347 (Del. 1980); *Saikewicz*, 373 Mass. at 736, 744, 370 N.E.2d at 423, 427; *In re Quinlan*, 70 N.J. at 41, 355 A.2d at 664; *In re Storar*, 52 N.Y. 2d 363, 420 N.E.2d 64, 438 N.Y. 2d 266, *cert. denied*, 454 U.S. 858 (1981).

in most circumstances, is the family and close loved ones of the patient.[30]

IV. IN *CRUZAN*, THE MISSOURI SUPREME COURT IMPROPERLY FORMED AND APPLIED THE BALANCING OF THE PATIENT'S CONSTITUTIONAL RIGHT AND THE STATE'S INTEREST SO AS TO IMPINGE UNJUSTIFIABLY ON THIS CONSTITUTIONALLY PROTECTED RIGHT.

Whether under the right of privacy or the Fourteenth Amendment Due Process Clause, the right to forgo life-sustaining medical treatment is not absolute when faced with a competing state interest. *Roe v. Wade*, 410 U.S. at 154; *Griswold v. Connecticut*, 381 U.S. at 485. An individual's right to forgo medical treatment is to be balanced against the purported state's interest. The Missouri Supreme Court erroneously formed and applied the balancing of Nancy Cruzan's right and the state's interests in that it effectively predetermined the outcome in favor of the state in most, if not all, cases. Such a balancing test is erroneous as a factual matter and is unconstitutional as an impingement on the patient's right of privacy or due process liberty right.

The Missouri Supreme Court identified four state interests to be balanced against the patient's right to forgo medical treatment: (1) "the preservation of life;" (2)"the prevention of homicide and suicide;" (3) "the protection of interests of innocent third parties;" (4) "the maintenance of the ethical integrity of the medical profes-

[30]*See, e.g., Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484, 492 (1983); *Jobes*, 108 N.J. 394, 529 A.2d 434, 444-47; *Quinlan*, 70 N.J. at 41, 355 A.2d at 671. Missouri recognizes a guardianship preference for blood relatives. Mo. Ann. Stat. §§ 475.050, 475.045 (Vernon Supp. 1989). *See also* AGS Position Statement, App. at 2a; President's Commission, *Deciding to Forego, supra* note 2, at 4-5.

sion." 760 S.W.2d at 419 (citing to Mo. Rev. Stat. § 459.055(1) (1986) and *Brophy*, 497 N.E.2d at 634).[31] In balancing, the Missouri Supreme Court only considered the state interest in the preservation of life, and improperly disregarded the three other legitimate state interests.[32] 760 S.W.2d at 419. By interpreting the state interest in the preservation of life as unqualified, the court understated the role of quality of life in the context of medical decision-making. The court also improperly considered the absence of burdensomeness to the patient in the balancing analysis. In this way, the Missouri Supreme Court erected a framework for balancing that will, in almost all cases, predetermine a result in favor of the state's interests, allowing the state effectively to become the ultimate decision-maker, thus impinging on the patient's constitutionally protected rights. With the recognition of the state's interest in the maintenance of the ethical integrity of the medical profession, the state's proper role becomes the monitoring of medical treatment decisions by insuring that the decision-making process is implemented in good faith and without serious conflicts of interest.

By recognizing only an *unqualified* state interest in the preservation of life,[33] the Missouri Supreme Court effectively predetermines the outcome of the balancing test; the patient's constitutionally protected interests cannot survive the balancing under any circumstance and all other state's interests are subsumed. The

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[31]*See, e.g., Tune*, 602 F. Supp. at 1455; *Rasmussen*, 154 Ariz. at 216, 741 P. 2d at 683; *Bartling*, 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225; *Foody*, 40 Conn. Supp. at 132-34, 482 A.2d at 718; *Bludworth*, 452 So. 2d at 924; *Satz*, 362 So. 2d at 162; *Conroy*, 98 N.J. at 348, 486 A.2d at 1223; *In re Farrell*, 108 N.J. 335, 529 A.2d 404, 410-11 (1987); *Saikewicz*, 373 Mass. at 740, 370 N.E.2d at 425; *Colyer*, 99 Wash. 2d at 122, 660 P.2d at 743.

[32]The decision by the Missouri Supreme Court goes against the clear intent of the statute relied upon to express the interest in life, Mo. Rev. Stat. § 459.055(1) (1986), by ignoring the three remaining interests.

[33]The Missouri Supreme Court defines the state interest in life as embracing two separate concerns: (1) an "interest in the prolongation of life of the individual patient," and (2) an "interest in the sanctity of life itself," 760 S.W.2d at 419.

Missouri Supreme Court also understated the role of quality of life concerns in the context of medical decision-making. As the Missouri court states:

> [S]ome courts find quality of life a convenient focus when justifying the termination of treatment. . . . Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives. Instead, the state's interest is in life; that interest is unqualified.

760 S.W.2d at 420.

The court below correctly raises the concern that the state should never make quality of life determinations, but it fundamentally misstates the proper role of "quality of life" in the decision-making process. It is the patient or the patient's representative, not the state, who is presented with the set of treatment options and who chooses an option, based on how the patient does (or would) judge the relative merits of the quality and length of life offered by each alternative. The decision is not and must not be allowed to be the proper domain of the state -- to allow the state this role would bring life to the Missouri Supreme Court's concerns. The state's *only* relationship to this decision must be limited, but is critical: To ensure a procedural environment in which the decision can properly be made in good faith. *See* L. Tribe, *American Constitutional Law*, § 16-31, at 1598-1601 (2d ed. 1988).

In fact, the feared world in which the state would seek to put the handicapped or "undesirables" to death seems more likely when, as under the rationale of the court below, the decision as to the patient's fate is the state's rather than when it is left to the patient or those, such as the patient's family, who love the patient and must live with the decision. Again, the decision to continue life-sustaining medical treatment is a decision in itself. Allowing the state a heavy-handed authority to "err on the side of life," 760 S.W.2d at 422, 426, is very different from allowing the family to individualize the decision; it not only is a disservice to present patients, but also leaves open the possibility that someday the state might decide to "err"

tne other way. This dangerous and illegitimate role for the state is inconsistent with a free and open society.

To acknowledge that all medical decisions involve how a life gets lived is also to acknowledge that medicine, like other human endeavors, is concerned primarily with enhancing or, at least, not diminishing the quality of people's lives. Medicine can rarely substantially prolong life, can never do so indefinitely, and can mainly affect the comfort or ease with which a life is lived. Thus, it is difficult, if not impossible, for the medical community to practice according to an unqualified interest in the preservation of life.

The AGS concurs with the American Neurological Association that the ruling of the Missouri Supreme Court ultimately undermines the state's asserted interest in preserving life by discouraging medical practitioners from urging a patient (through patient's family or guardian) to employ artificial life support, because they know that such a decision will subsequently be irrevocable.[34] The practice of medicine is necessarily imprecise and often the best information as to likely outcome is generated by a trial of treatment. The Missouri Supreme Court ruling would make such trials very troubling, for they could result in an inescapable prolongation of suffering.

In failing to consider the remaining state's interests, the Missouri Supreme Court has overlooked any consideration of the state's interest in the maintenance of the ethical integrity of the medical profession.[35] By ignoring this factor, the court has threatened one of

[34]Brief of the American Academy of Neurology as Amicus Curiae in Support of the Petition at 8-9, *Cruzan v. Director of Missouri Dept. of Health*, On Petition for a Writ of Certiorari to the Supreme Court of the State of Missouri (No. 88-1503).

[35]The ethical integrity of individual caregivers is separable from the ethical integrity of the medical profession as a whole. Conscientious objection by a caregiver to a proposed plan of care, including the forgoing of artificial nutrition and hydration by any patient, can be, and ordinarily is, either accommodated by a transfer of the patient to another facility or to the patient's home, or a change in the attending caregiver within the same facility.

the bases of the medical profession's ethical integrity: an accepted and practiced ethical model for good medical decision-making.[36]

Previous court decisions[37] have concluded that the state interest in the ethical integrity of the medical profession is not at issue since many professional organizations' pronouncements have favored allowing the forgoing of nutrition and hydration in certain circumstances.[38] For the Missouri Supreme Court to claim that the

[36]The prevention of homicide and suicide is a valid state concern which is reflected in and likely protected by the state interest in the preservation of life. Although the Missouri Supreme Court did not express a rationale for its dismissal of this state interest, health care professionals are particularly concerned about the circumstances under which a decision to forgo artificial nutrition and hydration, and other forms of life-sustaining treatment, might be construed as homicide or assisted suicide. Other courts have stated that such forgoing should not be thus construed. *Tune*, 602 F. Supp. at 1455 n. 8; *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674, 685 (1987); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220, 225-26 (1984); *Bouvia*, 179 Cal. App. 3d at 1127, 225 Cal. Rptr. at 297; *Foody*, 40 Conn. Supp. at 137, 482 A.2d at 720; *Saikewicz*, 373 Mass. at 743 n. 11, 370 N.E.2d at 426 n. 11; *Colyer*, 99 Wash. 2d at 121, 660 P.2d at 743. The state's interest in the protection of the interests of innocent third parties, also was disregarded by the Missouri Supreme Court. Other courts have limited this interest to situations in which a dependent of the patient might be adversely affected by the patient's decision. *See, e.g., In re Conroy*, 98 N.J. at 353, 486 A.2d at 1225; *Delio v. Westchester County Medical Center*, 129 A.D. 2d 1, 516 N.Y.S. 2d 677, 693 (App. Div. 1987); *Application of the President and Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1008 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

[37]*See, e.g., Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626, 638 (1986); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1224-25 (1985); *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417, 426.

[38]American Medical Association Council of Ethical and Judicial Affairs, Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association 12-13 (1986); American Nurses' Association, *Committee on Ethics: Guidelines on Withdrawing or Withholding Food and Fluid* (Jan. 1988); American Academy of Neurology, *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, reprinted in* 39 Neurology 125 (1989); American Society for Parenteral and Enteral Nutrition, *Stan-*

foregoing of artificial nutrition and hydration should categorically be proscribed is to deny professional judgment of whether this forgoing is ethically permissible in a particular case.

The decision of the Missouri Supreme Court has jeopardized the ethical integrity of the medical profession by directly interfering in the decision-making process, forcing health care professionals to disregard the patient-centered standard for good decision-making. Properly stated, the role of the state should be to *oversee* the medical decision-making process, not to be the surrogate decision-maker. "The state should stand ready to provide a neutral inquiry into the basis of the treatment decision." L.Tribe, *supra*, p. 23, § 16-31, p. 1601.

Further, the Missouri Supreme Court's analysis of the burden of treatment, 760 S.W.2d at 423-24, is defective because it would require treatment for at least all patients that could not feel or experience pain. This analysis is not grounded in the principles of medical decision-making and suggests that no treatment would ever be burdensome or otherwise contrary to the interests of patients suffering from a loss of sensation and mentation. The Missouri court identified a diagnosis of PVS as requiring unique consideration. Under their analysis, Nancy Cruzan is not terminally ill, and cannot be harmed by the continuation of gastrostomy feeding. 760 S.W.2d at 424. They conclude, therefore, that there is no justification for the feeding to be stopped.[39]

PVS is characterized by the permanent loss of all possibility for experience.[40] People reasonably differ as to whether such a per-

dards for Nutrition Support: Hospitalized Patients (Jan. 1984); *Position of the American Dietetic Association: Issues in Feeding the Terminally Ill Adult*, 87 ADA Reports 78-85 (1987).

[39]If this court rules that nutritional support cannot be withdrawn from Nancy Cruzan, it should, however, carefully restrict the application of its rationale only to PVS patients, since all others can be quite directly made to suffer by imposed and unwarranted treatment.

[40]American Academy of Neurology, *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, reprinted in* 39 Neurology 125 (1989). *See generally In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987); *Brophy*, 398 Mass. 417, 497 N.E.2d 626.

son should be given medical treatment aimed to delay death, and whether they would want continued treatment in a similar situation. Most of the reasons for treatment are gone: better function, fewer symptoms, or greater opportunities to achieve life's ends. Many individuals value the opportunity for human interaction above the mere absence of pain. In addition to publications and court cases that the majority opinion itself quotes,[41] the most recent Baby Doe regulations, that are intended to ensure protection for the sanctity of life, also regard irreversible coma as a condition that does not require life-sustaining treatment.[42] Many would argue that it is morally permissible to forgo all life-sustaining treatment in patients that are permanently unconscious.[43]

To be meaningful and to ensure protection of a patient's constitutional rights, the balancing test must give due weight to the patient's wishes and interests, as ethical medical care now demands, and the state must be limited to ensuring that the medical decision-making process is implemented fully and in good faith. In all but the rarest circumstances, the state should yield to a decision that ensues from that process.

[41]*See* 760 S.W.2d at 412, 413 n.4.

[42]42 C.F.R. § 1340.15 (b)(2)(i) (1989).

[43]*See also* Paris & Fletcher, *Withholding of Nutrition and Fluids in the Hopelessly Ill Patient*, 14 Clinics in Perinatology 367-77 (1987); OTA, *supra* note 2, at 275-332; Hastings Center, *Guidelines*, *supra* note 2, at 57-62; President's Commission, *Deciding to Forego*, *supra* note 2, at 190; Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & van Eys, *The Physician's Obligation Toward Hopelessly Ill Patients*, 310 New Eng. J. Med. 955, 958 (1984); Wanzer, Federman, Adelstein, Cassel, Cassem, Cranford, Hook, Lo, Moertel, Safar, Stone & van Eys, *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 New Eng. J. Med. 844-849 (1989); Lynn & Childress, *Must Patients Always Be Given Food and Water?*, in *By No Extraordinary Means* 47-60 (Lynn ed. 1989); Steinbrook & Lo, *Artificial Feeding -- Solid Ground, Not a Slippery Slope*, 318 New Eng. J. Med. 286-290 (1988); American Medical Association, *supra* note 38, at Opinion 2.18.

CONCLUSION

For the foregoing reasons, the American Geriatrics Society as amicus curiae respectfully requests that the Missouri Supreme Court decision be reversed and the case remanded for a decision consistent with the Court's opinion ensuring the ethical integrity of the medical decision-making process and recognizing the authority of patients, through their surrogates, to forgo life-sustaining medical treatment.

Respectfully submitted,

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APPENDIX

AGS POSITION STATEMENT MEDICAL TREATMENT DECISIONS CONCERNING ELDERLY PERSONS

(NOTE: This position paper was developed by the Public Policy Committee and approved by the Board of Directors in May 1987.)

Background

The past few decades have seen much controversy and confusion over the limits of medical intervention. This is due to reasons such as increasing efficacy of medical techniques, the increasing burden of chronic illness in the population, the declining availability of close family, and increasing litigation. Decisions regarding the application of medical treatments to particular patients once concerned only a small group of involved persons. However, these decisions are now commonly subject to the attention of the public, of large groups of people providing care in institutional settings, and of law enforcement officials. This change has led to a need to be explicit about values, and, as would be expected in this pluralistic society, there have arisen profound disagreements over these values. Carefully developed guidelines for standards and procedures can prove helpful to guide caregivers, patients, and public policy. Such guidelines reflect (1) a strong commitment to personal autonomy; (2) both an appreciation of the beneficial potential of modern medicine and honesty regarding its side effects and limitations; and (3) an affirmation of the inestimable value of life and a clear recognition of the inevitability of death.

POSITIONS

1. Patients' interests are not always best served by applying all theoretically beneficial treatments. Instead, the choice made should reflect that patients often have legitimate concerns about avoiding suffering, advancing their occupational or family concerns, mitigating disabili-

ty, and sustaining independence. Particular medical interventions may not be warranted in light of overall effects on well being, although they may be expected to help a particular medical condition.

2. Physicians have the responsibility to communicate with patients and families so that informed choices regarding care reflect each patient's own priorities and evaluations of various projected outcomes.

3. Informed competent patients are capable of making reasoned choices that are determinant of medical care, except when there are substantially detrimental effects upon others or the choices conflict with legal or professional standards.

4. When patients cannot be informed or cannot reason about the available options in light of their own preferences and goals, the physician should, for any important decision or ambiguous choice, involve someone who knows the patient and can represent the patient's wishes in making a choice. This surrogate is often a close family member or could be a concerned friend. If the patient has no appropriate surrogate, practitioners and institutions should arrange for substitutes by developing procedures (such as biomedical ethics committees) that do not require routine recourse to formal guardianship proceedings.

5. Whenever possible the patient should be encouraged to state his or her preferences in advance of decision-making incapacity. Such a statement can be informal but should be appropriately noted in the medical record. Also, patients should be encouraged to make appropriate use of durable power of attorney and living will statutes.

6. Caregiving professionals and institutions should make available to patients a full range of options for treatment, including the option of supportive care for dying patients.

7. We encourage legislation at the state level to insure the availability of a range of options for patients, including statues defining durable powers of attorney for health and carefully structured living wills. Such legislation would provide authority, in most cases, for decision-making by appropriate surrogates and physicians without needing formal guardianship proceedings.